AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Medicare Red Tape Relief Project
Submissions accepted by the Committee on Ways and Means, Subcommittee on Health

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These suggestions are both **Statutory** and **Regulatory.**

Please describe the submitting organization's interaction with the Medicare program:

The American Academy of Family Physicians (AAFP) represents over 129,000 family physicians and medical students in the United States, and is the largest physician organization in the United States dedicated entirely to primary care. This year, the AAFP celebrates its 70th anniversary.

The over 70,000 active members of AAFP form a cornerstone of the delivery of Medicare services to America's seniors. According to the AAFP's most recent practice profile (published July 2017), nearly all (91 percent) of AAFP active members are fully participating in Medicare; only 4 percent are non-participating Medicare providers, and only 5 percent have opted out of Medicare. 83 percent of AAFP active members accept new Medicare patients. And Medicare enrollees represent 25 percent of the median patient panel size, for AAFP active members.

Item 1. Utilization Management – Prior Authorization

Short Description:

- Prior Authorization (PA) requirements in Medicare Parts B, C, and D represent one of the most burdensome requirements on family practices. PA rules consume valuable physician time as family physicians must justify decisions that they can make independently based on their training, experience, and judgment. In extreme cases the PA process can even delay important and necessary treatments to patients.

Summary:

- Medicare Advantage (MA) and Medicare Part D plans have wide latitude to establish PA requirements and other similar utilization-management tools. Medicare Part B employs fewer PA tools but does have some restrictions—particularly for certain items of durable medical equipment (DME). These rules vary widely across the Medicare spectrum, and require family physicians and staff to spend precious clinical time managing phone calls, faxes, and filling out forms, in order to receive authority to order items and services that they deem necessary for diagnosis and treatment of their patients.

- In addition, since a majority of family physician practices have contractual relationships with seven or more payers, they must navigate seven or more different sets of PA rules and forms. These rules and forms substitute the training, experience, and judgment of the physician who is physically present at the patient's side, with a maze of rules that ultimately determine whether payment for an item or service will be allowed.

Related Statute / Regulation:

- **Section 1852(c)(1)(G)** of the *Social Security Act* requires MA plans to disclose "in clear, accurate, and standardized form . . . rules regarding prior authorization or other review requirements that could result in nonpayment."

- Medicare Managed Care Manual

Proposed Solutions:

1. Congress should establish a blanket statutory prohibition on prior authorization in Medicare Parts B, C and D for items below a certain threshold of cost (in particular if the cost of the item is less than the value of the physician or clinician time needed to secure PA). In general this would include, at a minimum, (1) generic drugs, and (2) all standard and inexpensive drugs. The prohibition should also apply to ongoing use of a drug or item by a patient with long-term chronic disease (e.g. supplies for diabetic patients), for which PA should be unnecessary.

2. Congress should require CMS to establish a single, standardized prior-authorization form and process that would apply in Part B, and flow down to all Medicare Part C and D plans (as well as all payers outside of the Medicare program).

3. For extremely burdensome instances of PA (e.g. those that exceed a certain number of steps or that are not resolved within a certain period of time), Congress should require Medicare Part B and Part C and D plans to pay family physicians and other ordering professionals for their time in resolving these matters.

Item 2. Utilization Management -- Appropriate Use Criteria for Advanced Imaging

Short Description:

- The impending requirement that physicians who order advanced imaging services for their Medicare Part B enrollees consult with "qualified decision support mechanisms" will create new and significant administrative burdens on family physicians who order these important diagnostic services.

Summary:

- In 2014, Congress enacted the *Protecting Access to Medicare Act* (PAMA), which requires CMS to establish a "program to promote the use of appropriate use criteria . . . for applicable imaging services." As with PA rules, the AUC program is a utilization management system that will require ordering professionals (such as family physicians) who participate in Medicare to consult "qualified decision support mechanisms" before ordering diagnostic tests such as CT, MRI and nuclear medicine. Under the CY2018 proposed Medicare Physician Fee Schedule (MPFS) (82 Fed. Reg. at 34,096), CMS proposes that "ordering professionals must begin consulting specified applicable AUC through qualified CDSMs for applicable imaging services ordered on and after January 1, 2019."

Related Statute / Regulation:

- *Social Security Act* **Section 1834(q)**, added by PAMA.

Proposed Solution:

- The AAFP would propose that Congress repeal section 1834(q) of the *Social Security Act*, which has been in effect superseded by subsequent Congressional action. The policy objective animating the AUC program is also embedded in the recently-launched Medicare Quality Payment Program (QPP) for physicians, which Congress subsequently established under MACRA in 2015. Once fully implemented, adjustments under MIPS will reflect performance in resource management (which CMS calls the "cost" performance category), which is designed to incentivize ordering professionals such as family physicians to exhaust lower-cost clinically appropriate options before ordering more costly advanced imaging services. Similarly, the eligible APMs under MACRA have built-in incentives to reduce unnecessary utilization of advanced imaging. Under MIPS, clinical decision support mechanisms could be useful—but they should be optional.

Item 3. Translation Services

Short Description:

- As of October 17, 2016, new limited English proficiency (LEP) policies created costly new burdens on family physicians who participate in Medicare Advantage (as well as other federal payers outside Part B such as Medicaid and health plans on the ACA exchanges). The policies require covered physician practices to "take reasonable steps to provide meaningful access" to patients with LEP who are enrolled in MA plans, by providing a qualified interpreter.

Summary:

- The AAFP agrees that communication is of critical importance to helping patients—particularly in primary care. High-quality family medicine is invariably patient-centered and rooted in long-term caring relationships with patients and communities. Management of complex chronic conditions requires patient engagement, as well as ongoing collaboration and consultation between physician and patient. None of this is possible without effective verbal and written communication. Therefore, the AAFP supports the policy goals animating this rule, which requires family practices to provide translation services in multiple languages.

- However, family medicine practices must be paid for the cost of adding such services to their practices. Family medicine practices already operate on slim financial margins. The AAFP strongly believes that Congress and HHS must procure the necessary funding to address and offset the financial burden that this mandate imposes on our members and all physicians. The expense of translation services is not an element that CMS prices into the valuation of physician office visit codes—which are already chronically undervalued under the existing resource-based relative value scale (RBRVS) employed by CMS. Moreover, if a patient with LEP cancels or reschedules an appointment, the family medicine practice must still pay the interpreter.

Related Statute / Regulation:

- **45 CFR Section 92.201(a)** requires that "a covered entity shall take reasonable steps to provide meaningful access to each individual with limited English proficiency eligible to be served or likely to be encountered in its health programs and activities."
- **45 CFR Section 92.201(c)** provides: "Language assistance services required under paragraph (a) of this section must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with [LEP]."
- **45 CFR Section 92.201(d)** requires that "a covered entity shall offer a qualified interpreter to an individual with [LEP] when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency."

Proposed Solution:

- Congress should pay family medicine practices for the cost of providing translation services. Alternatively, Congress should work with HHS to remove the mandate and allow practices to provide translation services at their discretion, depending on the circumstances of their practice and patient needs.

Item 4. Documentation Requirements for Evaluation and Management Services

Short Description:

- The CMS Documentation Guidelines for Evaluation and Management (E/M) Services that are currently in force create unnecessary burdens for family physicians, and should be eliminated.

Summary:

- Family Physicians rely heavily on the E/M service code set for outpatient physician office visits (CPT 99201-99205 for new patients; and CPT 99211-99215 for established patients) to bill Medicare Part B and MA plans for their services. The current CMS Documentation Guidelines for E/M Services, established 20 years ago, do little to support patient care, and serve more as a framework to help physicians justify their level of billing (e.g. level 3, 4, or 5), than they do a framework to help physicians diagnose, manage, and treat patients. Adherence to the guidelines consumes a significant amount of physician time, and does not reflect the workflow of primary care physicians. Further, the guidelines were drafted for use with paper-based medical records, and do not reflect the current use and further potential use of electronic health records and team-based care. Many AAFP members believe that the Guidelines also negatively impact the usability of EHR software programs.

- The Committee should note that CMS has announced a Public Comment Solicitation in the most recent proposed physician fee schedule (dated July 21, 2017), in which it asks for public comment on "whether it would be appropriate to remove our documentation requirements for the history and physical exam for all E/M visits at all levels."

Related Statute / Regulation:

- The 1995 and 1997 Documentation Guidelines for Evaluation and Management Services

Proposed Solution:

- Congress should work with CMS to eliminate these Guidelines.

Item 5. Simplification and Harmonization of Quality and Performance Measures

Short Description:
The dizzying number and variety of quality-measure regimes among payers has led to significant compliance cost and wasted time for family physicians. This unnecessary burden can be eliminated through the adoption of a single standardized set of clinical quality measures across all public and private payers.

Summary:
The health-care sector has witnessed an explosion of quality and performance measures over the last 10 years. Physicians, especially family physicians, bear the brunt of these measures in terms of administrative burden and compliance cost. A major part of this is the burden is the lack of standardization or harmonization or alignment among multiple performance measure programs across multiple payers. Half of family physicians contract with seven or more payers, including Medicare Part B, MA plans, state Medicaid programs, Medicaid MCOs, and a variety of local, regional, and national health plans. Many of these payers are free to adopt their own variations of quality and performance measures, which gives rise to frustrating burdens and costs that cause physicians to spend less time with patients, and are a contributing factor to physician dissatisfaction and burnout.

To standardize quality and performance measurement, CMS has convened a multi-stakeholder process (called the Core Quality Measures Collaborative)—which includes the AAFP—to develop consensus core sets of measures. This Collaborative has published the first version of such a core set of measures for primary care.

Related Statute / Regulation:
- **Section 1848(q)(2)(B)(i)** of the *Social Security Act* requires CMS, for physicians being paid under MIPS, to use the measures from an "annual final list," as well as a list of quality measures "used by qualified clinical data registries."

Proposed Solution:
- Congress should establish a timetable for all public and private payers to adopt the consensus-driven core quality measure set as part of the "annual final list" of quality measures under MIPS. On the same timetable, Congress should require all public and private payers to adopt these same sets of measures. Further, public and private payers should be required to retire any measures not included within the consensus-driven measure set.

Item 6. Chronic Care Management Services

Short Description:

- Since 2015, Congress has required CMS to pay physicians for chronic care management (CCM) services. While this is a positive development for Medicare enrollees, the elements and billing requirements for the codes are overly complex; in addition, the monthly collection of coinsurance for Medicare enrollees who lack supplemental coverage is particularly challenging, because the service is not performed face-to-face with the patient.

Summary:

- CCM services are non-face-to-face services that a patient's primary care physician performs monthly, to help coordinate and manage the overall care for patients with multiple chronic conditions. CCM covers a wide range of activities but can include services like: creating plans of care, reviewing lab reports, consulting with specialists, communicating with patients by phone or email, and submitting prescriptions. CMS now pays physicians for at least three chronic care management services: 99490 (the standard CCM service), 99487 (CCM services for more complex patients), and 99489 (additional 30 minutes of clinical time for CCM).

- The service elements and billing requirements for CCM remain overly complex and burdensome for family physicians. Although CMS has made progress in simplifying them since inception of the first CCM code in 2015 (most recently in the CY2017 Medicare Physician Fee Schedule (PFS)), further work is necessary to encourage greater uptake of the codes among family physicians.

- In addition, beneficiaries—even those who could benefit from CCM services—often are not willing to pay a monthly coinsurance for services that occur when they are not physically present in the physician office—particularly when other preventive services carry no cost-sharing requirement. Additionally, collecting the approximately $8 from patients who do not come to the office in a given month can be logistically challenging. Ultimately, what amounts to a relatively modest monthly fee is dissuading beneficiaries from receiving services that are designed to keep them healthy and avoid the need for more costly face-to-face services later. CMS, in its CY2017 PFS, stated (at p. 80,243) "we currently have no legislative authority to 'waive' cost sharing for this service."

Related Statute / Regulation:

- **Section 1848(b)(8)** of the *Social Security Act* (added by MACRA) requires CMS to make payment "for chronic care management services furnished on or after January 1, 2015."

- The current service elements and billing requirements for CCM appear in the most recent Medicare PFS, at **81 Fed. Reg. 80,251 (Nov. 15, 2016).**

Proposed Solutions:

- Congress has legislated on this specific service, and thus should ensure that administrative barriers do not stifle its widespread adoption. **First**, Congress should work with CMS to greatly simplify the service elements and billing requirements for CCM services. **Second**, Congress should establish new authority to allow CMS to waive beneficiary cost sharing for the CCM services.